CHOICE MODEL SERVICES AGREEMENT

Choice Model Services Agreement
Deschutes County Health Services

Effective: January 1, 2024 – June 30, 2025

This Choice Model Services Agreement is entered into effective as of the 1st day of January 2024 (hereinafter referred to as the Effective Date) by and between**, PacificSource Community Solutions,** an Oregon non-profit corporation (**"Health Plan"**) and **Deschutes County Oregon, a political subdivision of the State of Oregon, acting by and through Deschutes County Health Services** (**"Provider"**) and shall expire on the 30th day of June 2025 unless extended or terminated earlier in accordance with its terms.

RECITALS

WHEREAS, Health Plan is Contracted with the State of Oregon, acting by and through the Oregon Health Authority ("OHA"), Health Systems Division ("HSD"), to implement and administer services under the Oregon Health Plan and other target populations as defined in this agreement;

WHEREAS, Health Plan desires to enter into this Agreement with Provider to provide Covered Services to Individuals as described in this Agreement.

WHEREAS, the parties intend that should any ambiguity arise in the interpretation of a provision of this Agreement, the provision shall be construed to be consistent with the legal requirements of the state of Oregon, any Agreements between Health Plan and state or government agencies, or other legal requirements, as applicable.

NOW, THEREFORE, in consideration of the mutual covenants and agreements, and subject to the conditions and limitations set forth in this Agreement, and for the mutual reliance of the parties in this Agreement, the parties hereby agree as follows:

AGREEMENTS

1. **Definitions.**

   1.1 "Acute Care Psychiatric Facility" or "Acute Care Psychiatric Hospital" shall mean a hospital that provides 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 years of age or older with serious psychiatric disabilities.

   1.2 "Agreement" shall mean this Choice Model Services Agreement, including any and all amendments, exhibits, attachments, schedules, and addenda, now or hereafter entered into, between Provider and Health Plan.

   1.3 "Assertive Community Treatment (ACT)" shall mean an evidence-based practice designed to provide comprehensive treatment and support services to Individuals with SPMI. ACT is intended to serve Individuals who have serious functional impairments and who have not responded to traditional psychiatric outpatient treatment. ACT

services are provided by a single multi-disciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers, and are designed to meet the individual needs of each Individual and to help keep the Individual in the community and out of a structured service setting, such as residential or hospital care. ACT is characterized by:

a. Low client to staff ratios;

b. Providing services in the community rather than in the office;

c. Shared caseloads among team members;

d. 24-hour staff availability;

e. Direct provision of all services by the team (rather than referring Individuals to other agencies); and

f. Time-unlimited services.

1.4 "Behavioral Health Treatment" shall mean treatment for mental illness, substance use disorders, or problem gambling.

1.5 "County of Responsibility" (COR) shall mean the county in which an Individual most recently maintained a postal address, or if residence is otherwise indeterminate, the county where the Individual was last present before being transported to an acute psychiatric hospital such as where the Individual was placed on a police officer custody, director's custody or transport custody. Incarceration or placement on an involuntary hold, at OSH or a licensed 24-hour facility, is not to be used to make this determination. OHA will determine COR if there is a disagreement between counties.

1.6 "Discharge Plan" shall mean a written document prepared by the Provider beginning at admission and updated through the Discharge Planning process which identifies housing, treatment and other services needed to support the continuity of care necessary to maintain the Individual's stability in the community. This report shall combine information from the Individual, OSH, community providers, recovery plan, and other resources.

1.7 "Discharge Planning" shall mean a process that begins upon admission to OSH or licensed residential setting and is based on the presumption that with sufficient supports and services, all Individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the Individual has a primary role in creating, and is based on principles of self-determination.

1.8 "Exceptional Needs Care Coordination (ENCC)" shall mean a process-oriented activity to facilitate ongoing communication and collaboration with the Individual to arrange Services appropriate to their needs, preferences and choices, including but not limited to:

a. Facilitating communication between the Individual, family, natural supports and community resources, involved providers, and agencies;

b. Organizing, facilitating, and participating in interdisciplinary team meetings when the Individual is in the community in collaboration with CCO Care Coordinators;

c. Emphasizing discharge planning in IDTs at OSH by collaborating with IDT members, providing recommendations in collaboration with CCO Care Coordinators towards discharge preparation and sharing revisions of the Discharge Plan;

d. Providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for adults with SPMI; and

e. In collaboration with CCO Care Coordinators, facilitating all referrals from OSH with the goal of providing oversight and care coordination for Adults with SPMI.

1.9 "Face-to-Face" shall mean a personal interaction where both words can be heard and facial expressions can be seen in person or through telehealth services where there is a live streaming audio and video.

1.10 "Home and Community-Based Services (HCBS)" shall mean the 1915 (i) state Medicaid plan amendment that allows for the use of Medicaid funding for home-based habilitation, behavioral habilitation, and psychosocial rehabilitation services for qualified Medicaid recipients who have been diagnosed with a mental illness.

1.11 "Home CCO" shall mean enrollment in a Coordinated Care Organization (CCO) in a given service area, based upon an Individual's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization per enrollment requirements in OAR 410-141-306 and OAR 410-147-3815.

1.12 "Individual" or "Client" shall mean, with respect to a particular Service, any person who is enrolled in that Service, in whole or in part, with payments provided under this Agreement.

1.13 "In-Reach Services" shall mean services delivered from community-based service providers to an Individual while at the Oregon State Hospital (OSH) or acute care psychiatric hospital to:

a. Maintain the Individual's connection to ongoing services and supports;

b. Assist with stabilization and discharge planning; and

c. Provide transition support for Individuals determined Ready to Transfer from the OSH or determined appropriate for diversion from OSH while in an acute care psychiatric hospital.

1.14 "Integrated Setting" shall mean a setting that enables Individuals with disabilities to interact with non-disabled persons to the fullest extent possible. Integrated settings are those that provide Individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are:

a. Located in mainstream society;

b. Offer access to community activities and opportunities at times, frequencies and with persons of an Individual's choosing;

c. Afford Individuals choice in their daily life activities; and

d. Provide Individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible.

1.15 "Long-Term Psychiatric Care (LTPC)" shall mean inpatient psychiatric services delivered in an Oregon State-operated Hospital after

a. Usual and customary care has been provided in an acute inpatient hospital psychiatric care setting;

b. The Individual continues to be unsuccessful in an alternative setting; and

c. The Individual continues to require a hospital level of care.

1.16 "Oregon State Hospital (OSH)" shall mean any campus of the Oregon State Hospital system.

1.17 "Peer Delivered Services" shall mean community-based services and supports provided by peers, and Peer Support Specialists, to Individuals or family members with similar lived experience. These services are intended to support Individuals and families, to engage Individuals in ongoing treatment, and to live successfully in the community.

1.18 "Ready To Transition (RTT)" shall mean the date that, consistent with the scope of the order of commitment, OSH has determined that an Individual is no longer in need of hospital-based care as described in OAR 309-091-0035.

1.19 "Records" refers to all financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Provider whether in paper, electronic or other form, that are pertinent to this Agreement.

1.20 "Recovery" shall mean a process of change through which Individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

1.21 "Recovery Plan" shall mean a written document created by the Individual and facilitated by a Peer Support Specialist, or an alternative as determined by the Individual, to help identify the Individual's strengths (e.g. knowledge gained from dealing with adversity, personal or professional roles, talents, personal traits) that can act as resources to the Individual and the Individual's recovery planning team in pursuing personal and treatment goals.

1.22 "Serious and Persistent Mental Illness (SPMI)" shall mean the current DSM diagnostic criteria for at least one of the following conditions, as a primary diagnosis for an adult 18 years of age or older:

a. Schizophrenia and other psychotic disorders;

b. Major depressive disorder;

c. Bipolar disorder;

d. Anxiety disorders limited to Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD);

e. Schizotypal personality disorder; or

f. Borderline personality disorder.

1.23 "Supported Housing" shall mean permanent housing with tenancy rights and support services that enables Individuals to attain and maintain integrated affordable housing. Support services offered to Individuals living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other

members of the community, with the same rights and responsibilities. Supported housing enables Individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site housing. To be considered supported housing under this Plan, for buildings with two or three units, no more than one unit may be used to provide supported housing for tenants with SPMI who are referred by Health Plan or its Providers, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for tenants with SPMI who are referred by Health Plan or its Providers. Supported housing has no more than two Individuals in a given apartment or house, with a private bedroom for each Individual. If two people are living together in an apartment or house, the Individuals must be able to select their own roommates. Supported housing does not include housing where providers can reject Individuals for placement due to medical needs or substance abuse history.

1.24 "Voluntary by Guardian" shall mean that an Individual's legal guardian has signed consent for admission to an acute psychiatric facility, Oregon State Hospital, or licensed residential facility.

2. **Service Description.**

2.1 Provider shall provide oversight and care coordination for Adults with Serious and Persistent Mental Illness (SPMI) as follows:

a. Facilitate access to quality individualized community-based services and supports so that adults with SPMI are served in the most integrated setting possible; and

b. Facilitate effective utilization of services and facility-based care in the community; and

2.2 Identify anticipated capacity needs across the system and communicate with Coordinated Care Organizations (CCO), Community Mental Health Programs (CMHP), and Oregon Health Authority (OHA).

2.3 The Provider's service area shall align primarily with the Home CCO and when no CCO is identified or the Home CCO has multiple Choice Providers, then the service area will align with the County of Responsibility (COR) as follows:

a. Home CCO is the designated service area for Individuals who are:

i. CCO enrolled members; or

ii. CCO members at the time of referral to Oregon State Hospital (OSH); or

b. COR is the designated service area for Individuals who are:

i. Fee-For-Service Medicaid Eligible;

ii. Uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid services, including those who meet the criteria for the Citizen Alien Waived Medical Program;

iii. Undocumented;

iv. Privately insured;

v. Funded through Veterans Administration; or

vi. Other as approved by OHA.

2.4 Service Population

Individuals who meet the following criteria shall be enrolled in Choice Model Services:

a. Have been civilly committed and admitted to OSH under ORS Chapter 426;

b. Have been civilly committed under ORS Chapter 426 and are referred to or at risk of being referred to OSH;

c. Admitted to OSH under guardian authorization; secured or non-secure licensed residential facility as defined in ORS 443.400 including licensed programs designated specifically for young adults in transition;

d. Are residing in a license adult foster home as defined in ORS 443.705 due to SPMI; or

e. As directed by OHA.

2.5 Individuals who, due to SPMI, meet the following criteria may be enrolled, per Provider's policies and procedures in Choice Model Services:

a. Are placed on outpatient commitment pursuant to ORS 426.127;

b. Are placed in assisted outpatient treatment pursuant to ORS 426.133;

c. Have transitioned from civil commitment pursuant to ORS 426.060 within the past 12 months;

d. Have been found to lack fitness to proceed pursuant to ORS 161.370;

e. Will end jurisdiction within the next six months or ended jurisdiction under the Psychiatric Security Review Board (PSRB) within the past 12 months;

f. Have been determined service eligible through the Department of Human Services (DHS), Aging & People with Disabilities (APD) and Intellectual/Developmental Disabilities (I/DD) Divisions to support the behavioral health service needs of Individuals determined service eligible for APD or I/DD; or

g. Are at risk of meeting the above criteria without supports offered through Choice Model Services.

2.6 Eligible Services

a. Exceptional Needs Care Coordination as appropriate to the needs, preferences, and choices of each Individual.

b. Coordination of behavioral health treatment services and supports not funded through other sources including, but not limited to:

i. Medicaid;

ii. Medicare;

iii. County Financial Assistance Agreements; or

iv. Coordinated Care Organization Contracts.

c. Activities to remove barriers and facilitate access to integrated services and supports, which are not funded through other sources. Especially when Individuals are being discharged from OSH and when establishing residence in Supported Housing. These activities may include, but are not limited to:

i. Room and board payments;

ii. Rental assistance, security deposits, and application fees;

iii. Utility payments and deposits;

iv. Prescription or over-the-counter medications and medical supplies not covered by Medicaid or other sources;

v. Transportation;

vi. Activities to secure and maintain Guardianship Services, including but not limited to:

a. Paying the costs of:

i. Court hearings to determine the necessity, continuation or termination of a guardianship.

ii. Guardianship services to make decisions related to overseeing the care and supervision of an Individual.

b. If guardianship is expected to continue beyond a transitional period of time (6 months or less) then other payment options should be sought in order to maintain guardianship services;

vii. Activities to secure and maintain representative payee services; or

viii. Peer Delivered Services.

d. Support CCO Care Coordination efforts to gather documents such as the Community Questionnaire, develop a preliminary discharge plan from OSH and sign for final authorization for the Long-Term Psychiatric Care referral.

e. Other services and supports necessary to facilitate provision of services in the most integrated setting and the prevention of admission to higher levels of care.

3. **Performance Requirements.**

Provider shall perform the following services:

3.1 Exceptional Needs Care Coordination for Individuals enrolled in Choice Model Services to facilitate access to services in the most integrated setting appropriate to the Individual's needs and strengths, including:

a. Care coordination and Discharge Planning for Individuals receiving services in licensed residential programs, even when placed outside the Provider's service area;

b. Facilitate access to community-based rehabilitative mental health treatment services that are recovery-oriented, culturally responsive, and geographically accessible;

c. Facilitate access to peer delivered services;

d. Serve as the Single Point of Contact (SPOC) for all referrals from OSH to Assertive Community Treatment as described in OAR 309-019-025 (25) Definition of SPOC in ACT Admission Process 309-019-0248;

e. Collaborate with CCO Care Coordination concerning Acute Care Psychiatric Hospitals to divert Individuals approved for LTPC from admission to OSH and toward community-based services and supports, when indicated to be appropriate;

f. Collaborate with the Department of Human Services (DSH), Aging & People with Disabilities (APD) and Intellectual/Developmental Disabilities (I/DD) Divisions to support the behavioral health service needs of Individuals determined service eligible for APD or I/DD;

g. Coordinate the transition from forensic services for Individuals ending jurisdiction under the Psychiatric Security Review Board within six months and who will be enrolled in Choice Model Services;

h. Coordinate the transition from forensic services for Individuals found to lack fitness to proceed pursuant to ORS 161.370 and who will be enrolled in Choice Model Services; and

i. Serve as a resource for community partners and service agencies in locating local community-based behavioral health treatment services and supports.

3.2 In collaboration with CCO Care Coordinators, facilitate transition for adults with SPMI out of hospital settings into the most integrated community settings by completing the following:

a. Provider will hold a face-to-face meeting with each individual within the Provider's service area being referred to OSH from Acute Care Psychiatric Hospitals prior to being referred but no later than seventy-two (72) hours from the date of approval for LTPC to identify services, and facilitate access to those services and supports in order to divert Individuals from admission to OSH whenever possible.

b. Provider will hold a face-to-face meeting with each Individual within the Provider's service area who is civilly committed, and to the extent practical for Voluntary by Guardian, admitted to OSH within seven (7) calendar days of admission.

c. Provider will participate in OSH IDT meeting for each Individual within the Provider's service area to update the Discharge Plan and to coordinate appropriate community-based services and supports.

d. Provider will arrange, advocate and coordinate appropriate In-Reach Services from CCOs and community providers who are delegated or identified as having responsibility for providing mental health services upon discharge.

e. Provider will facilitate development of a person-centered Discharge Plan within ten (10) calendar days of admission to OSH and update the plan as appropriate after each IDT or discharge planning meeting with the Individual.

f. Provider will coordinate and facilitate access to community-based resources of those civilly committed at OSH to support discharge from OSH within seventy-two (72) hours of being determined RTT whenever possible for Individuals with SPMI who have been civilly committed ensuring that:

   i. No less than 90% of Individuals shall be discharged within twenty (20) calendar days of being determined RTT.

   ii. If not discharged within the above timeframe then each Individual shall be discharged no later than sixty (60) calendar days from the date placed on RTT.

g. Provider will collaborate with OSH to verify that entitlement enrollments (e.g. Medicaid, Medicare, SSI/SSDI) are in place and active upon discharge.

h. For Individuals not enrolled in Choice Model Services, Provider will collaborate and serve as a resource to support Discharge Planning for Individuals:

i. Determined services eligible for APD or I/DD;

ii. Under the jurisdiction of ORS 161.370 to determine fitness to proceed; or

iii. Under the jurisdiction of the Psychiatric Security Review Board.

3.3 Transition Planning and Management.

a. Provider and Health Plan will collaborate to ensure utilization management of existing residential resources;

b. Provider and Health Plan will collaborate to ensure residential treatment coordination occurs to assist both non-Medicaid and Medicaid enrolled individuals who are not enrolled in managed care in transitioning between licensed facilities and from licensed facilities to independent living; and

c. Provider and Health Plan will collaborate to provide OHA with admission and discharge information for both non-Medicaid and Medicaid enrolled individuals who are not enrolled in managed care receiving personal care and rehabilitative mental health services in licensed community-based settings.

3.4 Develop and promote Peer Run and Peer Delivered Services.

a. Peer run and peer delivered services are provided by individuals who have successfully engaged in their own personal recovery and demonstrate the core competencies for Peer Support Specialists, as defined by OAR 410-180- 0300 through 410-180-0380, which may be revised from time to time;

b. Peer Support Specialists are compensated for delivering Peer Delivered Services;

c. The provider shall maintain policies and procedures that facilitate and document accessibility to a full range of peer run and peer delivered services;

d. Ensure each individual reported to OHA as an MHS 37 - Choice Model Services recipient has an individualized recovery plan subject to recipient choice; and

e. Match individuals with peers who are best suited to assist in achieving goals in the individualized recovery plan. These services are provided by individuals who share a similar experience and promote recovery.

3.5 Recovery-oriented services.

a. Develop recovery oriented services based on identified individual and community needs that are culturally responsive and geographically accessible; and

b. Develop purchasing strategies that encourage consumer self-direction, including but not limited to, developing voucher payment methods for some services.

3.6 Guardianship, conservator and/or payee.

a. Provider may establish criteria for financially supporting guardianship; and

b. Provider may prioritize support of court costs to establish non-paid family member as guardian.

3.7 Supportive and Supported Employment.

Choice Model payments may be used to purchase services and for system development as mutually agreed upon between Health Plan and Provider as prescribed in Choice Model Services procedures located at https://www.oregon.gov/oha/HSD/AMH/Pages/Choice-Model.aspx?wp3656=p:1&wp8654=p:1#g_8bd821e7_6e2e_4f47_b279_1a2ab30189af, as it may be revised from time to time.

4. **Monitoring and Administrative Functions.**

Provider shall perform the following monitoring and administrative functions:

4.1 Monitor the Choice Model Services Client outcomes, service access and utilization;

4.2 Analyze and prepare the Choice Model Services performance reports, which include outcomes, access and utilization;

4.3 Distribute and review reports with Provider management, Provider staff and Health Plan;

4.4 Document, track and report all qualifying events which justify performance payments as described in this Agreement;

4.5 Document and track individual's level of care movement against established benchmarks and performance standards to ensure clients are transitioning toward independent living;

4.6 Track outcomes, access and service utilization patterns and uses data to drive service delivery improvements;

4.7 Use reports and data to drive improvement processes at all levels; and

4.8 Submit all reports as directed within this Agreement which are complete and accurate within the prescribed time frames.

5. **Designating a Lead.**

Provider shall designate a staff person as the Choice Model Services Lead ("Lead"). Health Plan shall contact the Lead for all matters related to the work performed by Provider under this agreement.

The Lead shall:

5.1 Using the definition of the Choice Model Services target population, review medical record documentation, Level of Care Utilization System (LOCUS) results and other source materials to evaluate whether the Choice Model Services criteria is met and determines if each referral will be accepted into Choice Model Services and when clients will be discharged;

5.2 Receive and monitor RTT and ADP OSH reports;

5.3 Ensure the administration of the Level of Care Utilization System (LOCUS) at specified intervals and/or when clinical indicated as the client progresses through the continuum of care and ensure LOCUS supports individual's current Level of Care (LOC) placement within the continuum of care;

5.4 Perform care coordination, transitional planning and management which facilitates timely access to services and supports consistent with clinical needs of the client, and the Choice Model Services which includes monitoring utilization of the target population;

5.5 Coordinate local treatment planning team meetings and develop a plan which ensures a smooth and rapid transition to a lower level of care for clients in the service area temporarily residing at OSH;

5.6 Assure Provider is represented at all IDT meetings and ensure appropriate community based services and supports are developed and available prior to and upon IDT determination that the client no longer requires hospital level of services;

5.7 Coordinate all individual placements, receive and review clinical packets from OSH and make appropriate LOC referrals ensuring timely transfer of information required for placement;

5.8 Contact other Choice Model Services Leads throughout the state to facilitate placements when regional resources are not available;

5.9 Systemically monitor individual needs and provide assistance to ensure individuals have access to and obtain services, resources, and appropriate benefits in support of an individualized recovery processes;

5.10 Perform utilization management of existing residential resources by coordinating and tracking client transitions between licensed facilities, and from licensed facilities to independent living;

5.11 Work with providers to ensure clients are receiving recovery-oriented, culturally responsive, and geographically accessible services and supports which promote autonomy, community integration and independent living; and

5.12 Attend all Choice Model Services meetings hosted by Health Plan and disseminate information appropriately.

6. **Special Reporting Requirements.**

6.1 Provider shall prepare and electronically submit to Health Plan the following written reports using forms and procedures as prescribed on OHA's website, located at https://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx:

a. Maintain for reference but not submit policies and procedures for enrollment in Choice Model Services.

b. Monthly invoice specifying eligible expenditures for services and supports to eligible individuals shall be submitted no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th). Date range of the invoice time period must be specified on each invoice.

c. Monthly Choice Model Client Status Reports shall be submitted no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th) during the term of the Agreement for review and approval.

d. Any other reports as mutually agreed upon between OHA, Health Plan, and the Provider.

6.2 Upon Health Plan's identification of any deficiencies in the Provider's performance under this Agreement, including failure to submit reports as required, failure to expend available funding, or failure to meet performance requirements, Provider shall prepare and submit

to Health Plan within 30 calendar days a Corrective Action Plan (CAP) to be reviewed and approved by Health Plan. The CAP must include, but is not limited to, the following information:

a. Reason or reasons for the CAP;

b. The date the CAP will become effective with timelines for implementation;

c. Planned action already taken to correct the deficiencies as well as proposed resolutions to address remaining deficits identified with oversight and monitoring by Health Plan; and

d. Proposed remedies, short of termination, should Provider not come into compliance within the timeframe set forth in the CAP.

6.3 Provider shall submit the reports required under this Agreement via the PacificSource ShareFile platform.

Email: Katie.Huyck@PacificSource.com

Reports must be prepared using forms provided by the CCO Behavioral Health Clinical Quality Improvement Team.

7. **Responsibilities of Health Plan.**

Health Plan shall perform the following duties for the Choice Model Services program:

7.1 Interface with OHA Health Systems Division regarding Choice Model Services Agreement administration, planning, development, performance, payment or other issues as deemed necessary and appropriate by Health Plan, in its sole discretion;

7.2 Process payments received, and review, prepare and submit all Choice Model Services financial reports to OHA Health Systems Division;

7.3 Monitor Provider's performance to ensure all reports are accurate, complete and submitted within required timeframes and that performance standards are met;

7.4 Provide technical assistance as it relates to quality assurance and meeting performance requirements; and

7.5 Ensure corrective action plans are developed and submitted to OHA as needed which includes enforcement and tracking of corrective action plans through to resolution.

8. **Payment Calculation, Disbursement, and Settlement Procedures.**

8.1 Disbursement of Payment: Provider agrees to submit monthly invoices no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would be submitted to Health Plan on March 5th) for work performed on or after effective date and on or before termination date. Provider will be reimbursed by Health Plan via direct deposit within 30 (thirty) business days of monthly invoice submission. Annual payment for Choice Model Services shall be capped at: $696,146.96 for contract period January 1, 2024 through June 30, 2025. A performance payment of $36,041.35 for the time frame of January 1, 2024 through June 30, 2025

may be available if the applicable conditions described below are achieved for the entire region Health Plan's Choice Model contract covers. Refer to attached Table 1.

8.2 Calculation of Performance Payment: Contractor will qualify for a performance payment at the end of the calendar year if it was operational, as defined by serving Individuals for a minimum of 180 calendar days per fiscal year and who submit the Monthly Choice Model Client Status Report no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th) during the term of the contract and address any deficiencies identified by the Contract Administrator. All reports shall be submitted in accordance with the "Reporting Requirements" section above.

8.3 Disbursement of Carry-Over Funds. In the event there are undisbursed Choice Model Services funds from previous agreement periods, such funds will be disbursed based upon Provider invoice and brief description of proposed use of carry-over funds in addition to monthly Choice Model payments under this Agreement. Health Plan will evaluate proposals to assure compliance with the stated purpose of this Agreement and any other guidance from OHA for use of these funds.

8.4 Disbursement of Performance Payment. The performance payment is based on achievement of the performance criteria as prescribed in OHA's website located at http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx. Upon Health Plan's determination that Provider met or exceeded the performance criteria, Health Plan will request funds from OHA and distribute to Provider within 30 (thirty) days of receiving funds from OHA. The Performance Payment is only dispersed if both Central Oregon and the Columbia Gorge regions have met the criteria as outlined in 8.3.

8.5 Agreement Settlement. Agreement Settlement will be used to confirm implementation of the project described herein based on data properly reported. Payments will be recovered for unconfirmed services, as noted by incomplete or missing reporting requirements, as percentage of the payment made for that subject reporting period. There is no Settlement on Performance Payments.

9. **Attachments.**

The following attachments are incorporated herein and made a part hereof by this reference: Attachment A – Special Provisions; Attachment B – Standard Terms and Conditions.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties have executed this Agreement by and through their duly authorized representatives.

PACIFICSOURCE COMMUNITY SOLUTIONS		DESCHUTES COUNTY HEALTH SERVICES	
By:	_____	By:	_____ (Signature)
	_Peter McGarry_____		_____ (Print or type name)
Title:	_Vice President – Provider Network_	Title:	_____
Date:	_____	Date:	_____
Address:	PO Box 7469 Bend, OR 97708	Address:	2577 NE Courtney Drive Bend, OR 97701

Table 1

Deschutes County Health Services	
Payment Period January 1, 2024 through June 30, 2025	Not to exceed: $696,146.96
Eligible Performance Payment January 1, 2024 through June 30, 2025	$36,041.35
Performance payment is received only if all regions meet the required performance measure in Section 8.3 of the Choice Model Services Agreement.	

ATTACHMENT A

Special Provisions
Effective 07/01/2019

1. **Confidential Information:**

1.1 Client Information.

a. All information as to personal facts and circumstances obtained by the Provider on the client ("Client Information") shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the client, his or her guardian, or the responsible parent when the client is a minor child, or except as required by other terms of this Agreement. Nothing prohibits the disclosure of information in summaries, statistical, or other form, which does not identify particular individuals.

b. The use or disclosure of Client Information shall be limited to persons directly connected with the administration of this Agreement. Confidentiality policies shall be applied to all requests from outside sources.

c. If Provider, or any of its officers, directors, employees, agents, or subcontractors receives or has access to confidential Social Security Administration (SSA) or Federal Tax Information (FTI) records in the performance of Services under this Agreement, Provider shall comply, and ensure that all of Provider's officers, directors, employees, agents and subcontractors comply, with the following provisions:

i. With respect to SSA records:

A. Provide a current list of employees and employees of any agent or subcontractor with access to SSA records;

B. Adhere to the same security requirements as employees of OHA.

C. Abide by all relevant Federal Law, restrictions on access, use, disclosure, and the security requirements contained within OHA's agreement with SSA;

D. Provide its employees and agents the same security awareness training as OHA's employees; and

E. Include the provisions of this Section 1.1(c)(i) in any subcontract related to this Agreement.

ii. With respect to Federal Tax Information (FTI), as defined in IRS Publication 1075;

A. Provider and its officers, directors, and employees with access to, or who use FTI provided by OHA must meet the background check requirements defined in IRS Publication 1075;

B. Any FTI made available to Provider shall be used only for the purpose of carrying out the provisions of this Agreement. Provider shall treat all information contained in FTI as confidential and that information shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of Provider is prohibited;

C. Provider shall account for all FTI upon receipt and shall properly store all FTI before, during, and after processing. In addition, all FTI related output and products will be given the same level of protection as required for the source material;

D. No work involving FTI furnished under this Agreement will be subcontracted without prior written approval of the IRS;

E. Maintain a list of employees who are authorized access to FTI. Such list will be provided to OHA and, upon request, to the IRS reviewing office; and

F. Include the provisions of this Section 1.1(c)(ii) in any subcontract related to this Agreement.

iii. Failure to abide by any of the requirements in this subsection could result in criminal or civil penalties and result in termination of this Agreement.

iv. Provider may be subject to periodic and ongoing security reviews to ensure compliance with the requirements of Section 1.1(c).

d. Except as prohibited by Section 1.1(c) above, OHA, Health Plan, Provider and any subcontractor will share information as necessary to effectively serve Health Plan clients.

1.2 Non-Client Information.

a. Each Party acknowledges that it and any of its officers, directors, employees and agents may, in the course of performing its responsibilities under the Agreement, be exposed to or acquire information that is confidential to the other Party. To the extent permitted by law, any and all information of any form provided to a Party or its officers, directors, employees and agents in the performance of the Agreement that reasonably could at the time of its disclosure be understood to be confidential shall be deemed to be confidential information of the originating Party ("Confidential Non-Client Information").

b. Confidential Non-Client Information shall be deemed not to include information that:

i. Is or becomes (other than by disclosure by the Party acquiring such information) publicly known or is contained in a publicly available document except to the extent applicable law still restricts disclosure;

ii. Is furnished by the originating Party to others without restrictions similar to those imposed on the receiving Party under the Agreement;

iii. Is rightfully in the receiving Party's possession without the obligation of nondisclosure prior to the time of its disclosure by the originating Party under the Agreement;

iv. Is obtained from a source other than the originating Party without the obligation of confidentiality;

v. Is disclosed with the written consent of the originating Party; or

vi. Is independently developed by the receiving Party's officers, directors, employees and agents who can be shown to have had no access to the Confidential Non-Client Information.

1.3 Nondisclosure. The receiving Party shall hold all Confidential Non-Client Information in strict confidence, using at least the same degree of care that it uses in maintaining the confidentiality of its own confidential information; shall not sell, assign, license, market, transfer or otherwise dispose of, give or disclose Confidential Non-Client Information to third parties; shall not use Confidential Non-Client Information for any purposes whatsoever other than as contemplated by this Agreement or reasonably related thereto; and shall advise any of its officers, directors, employees and agents that receive or have access to the Confidential Non-Client Information of their obligations to keep Confidential Non-Client Information confidential. These confidentiality obligations do not restrict disclosure of information otherwise qualifying as Confidential Non-Client Information if the receiving Party can show that either of the following conditions exists: (i) the information was disclosed in response to a subpoena or court order duly issued in a judicial or legislative process, in which case the receiving Party shall notify the originating Party of the subpoena five days prior to the disclosure, unless such notice could not reasonably be given; or (ii) the disclosure was required to respond to a request for the information made under the Oregon Public Records Law, ORS 192.410 to 192.505. The receiving Party shall notify the originating Party of a public records request five days prior to the disclosure.

a. Upon request and pursuant to the instructions of Health Plan, Provider shall return or destroy all copies of Confidential Information, and Provider shall certify in writing the return or destruction of all Confidential Information.

b. "Client" means any individual, family or Provider:

i. For whom an Agency must provide Services and incidental or specialized Goods, in any combination thereof ("Services and Incidental Supplies"), according to state, federal law, rule, and policy. Those Services and Incidental Supplies include but are not limited to treatment, care, protection, and support without regard to the proximity of the services being provided;

ii. Who in fact receives and utilizes services provided by an Agency primarily for that individual's or family's benefit;

iii. Who is under the custody, care, or both of the Agency; or

iv. Who provides direct care or Services and is a proxy or representative of the non-Provider Client.

2. **Amendments.**

2.1 Health Plan reserves the right to amend or extend the Agreement under the following general circumstances:

1.1 Health Plan may extend the Agreement for additional periods of time up to a total Agreement period of 5 (five) years, and for additional money associated with the extended period(s) of time. The determination for any extension for time may be based on Health Plan's satisfaction with performance of the work or services provided by the Provider under this Agreement.

2.1 Health Plan may periodically amend any payment rates throughout the life of the Agreement proportionate to increases in Portland Metropolitan Consumer Price Index; and to provide Cost Of Living Adjustments (COLA) if Health Plan so chooses. Any negation of increases in rates to implement a COLA will be as directed by the Oregon State Legislature.

2.2 Health Plan further reserves the right to amend the Statement of Work for the following:

1.1 Programmatic changes, additions, or modifications deemed necessary to accurately reflect the original scope of work that may not have been expressed in the original Agreement or previous amendments to the Agreement;

2.1 Implement additional phases of the Work; or

3.1 As necessitated by changes in Code of Federal Regulations, Oregon Revised Statutes, or Oregon Administrative Rules which, in part or in combination, govern the provision of services provided under this Agreement.

2.3 Upon identification, by any party to this Agreement, of any circumstance which may require an amendment to this Agreement, the parties may enter into negotiations regarding the proposed modifications. Any resulting amendment must be in writing and be signed by all parties to the Agreement before the modified or additional provisions are binding on either party. All amendments must comply with the "Amendments; Waiver; Consent" provision of this Agreement.

3. **Provider Requirements to Report Abuse of Certain Classes of Persons.**

3.1 Provider shall comply with, and cause its employees, agents and subcontractors to comply with, the applicable laws for mandatory reporting of abuse including but not limited to abuse of the following classes of persons in Oregon:

1.1 Children (ORS 419B.005 through 419B.045);

2.1 Elderly Persons (ORS 124.055 through 124.065);

3.1 Residents of Long Term Care Facilities (ORS 441.630 through 441.645); and

4.1 Adults with Mental Illness or Developmental Disabilities (ORS 430.735 through 430.743).

3.2 In addition to the requirements of Section 3.1., if law enforcement is notified regarding a report of child abuse, Provider shall also notify the local Child Protective Services Office of the Department of Human Services within 24 (twenty-four) hours. If law enforcement is notified regarding a report of abuse of elderly, long term care facility residents, adults with mental illness or developmental disabilities, the Provider shall also notify the local Aging and People with Disabilities Office of the Department of Human Services within 24 (twenty-four) hours.

3.3 If known, the abuse report should contain the following:

a. The name and address of the abused person and any persons responsible for that person's care;

b. The abused person's age;

c. The nature and extent of the abuse, including any evidence of previous abuse;

d. The explanation given for abuse;

e. The date of the incident; and

f. Any other information that might be helpful in establishing the cause of the abuse and the identity of the abuser.

ATTACHMENT B

Oregon Health Authority Required Language
(Coordinated Care Organization, Non-Medicaid and OHP Bridge-BHP contracts)

In the event that any provision contained in this Exhibit conflicts or creates an ambiguity with a provision in this Agreement, this Exhibit's provision will prevail. Capitalized terms not otherwise defined herein shall have the meaning set forth in the OHA Contract, the Non-Medicaid Contract and/or OHP Bridge-BHP Contract (defined below and collectively referred to herein as "the OHA Contracts"). All Exhibit references in this Attachment B are to the exhibits in Contract # 161762-23 between OHA and Health Plan effective January 1, 2024. The parties shall comply with all applicable federal, state and local laws, rules, regulations and restrictions, executive orders and ordinances, the OHA Contracts, OHA reporting tools/templates and all amendments thereto, and the Oregon Health Authority's ("OHA") instructions applicable to this Agreement, in the conduct of their obligations under this Agreement, including without limitation, where applicable:

1. Provider must perform the services and meet the obligations and terms and condition as if the Provider is PacificSource Community Solutions ("Health Plan"). [Exhibit B, Part 4, Section 11(a)]

2. This Agreement is intended to specify the subcontracted work and reporting responsibilities, be in compliance with Health Plan's contracts with OHA to administer the Oregon Health Plan (the "CCO Contract"), the Non-Medicaid programs (the "Non-Medicaid Contract"), and the Oregon Health Plan Bridge-Basic Health Program Services Contract (the "OHP Bridge-BHP Contract"), and incorporate the applicable provisions of the OHA Contracts. Provider shall ensure that any subcontract that it enters into for a portion or all of the work that is part of this Agreement shall comply with the requirements of this Exhibit. [Exhibit B, Part 4, Section 11(a)]

3. Health Plan is a covered entity and the Parties agree that they will enter into a Business Associate agreement when required under, and in accordance with, the Health Insurance Portability and Accountability Act. [Exhibit B, Part 4, Section 11(a)]

4. Provider understands that Health Plan shall evaluate and document Provider's readiness and ability to perform the scope of the work set forth in this Agreement prior to the effective date, and shall cooperate with Health Plan on that evaluation. Provider further understands that OHA has the right to receive all such evaluations. Provider understands and agrees that Health Plan may utilize a readiness review evaluation conducted by Health Plan, or a parent company or subsidiary, in relation to a Medicare Advantage subcontract with Provider if the work in question under both contracts is identical and the evaluation was completed no more than three (3) years prior to the effective date of this Agreement. [Exhibit B, Part 4, Section 11(a)]

5. Provider understands that Health Plan must ensure that Provider, and its employees, are screened for exclusion from participation in federal programs and that Health Plan is prohibited from contracting with an excluded Provider, and shall cooperate by providing Health Plan with information to confirm such screening. [Exhibit B, Part 4, Section 11(a)]

6. Provider understands that Health Plan must ensure that Provider, and its employees, undergo a criminal background check prior to starting any work or services under this Agreement, and shall cooperate by providing Health Plan with information to confirm such checks. [Exhibit B, Part 4, Section 11(a)]

7. Provider understands that Health Plan may not Delegate certain work under the OHA Contracts and that this Agreement does not terminate Health Plan's legal responsibility to OHA for the timely and effective performance of Health Plan's duties and responsibilities under the OHA Contracts. Provider further understands that a breach by Provider of a term or condition in the OHA Contracts, as it pertains to work performed under this Agreement, shall be considered a breach by Health Plan of the OHA Contracts. Further, Provider understands that Health Plan is solely responsible to OHA for any corrective action plans, sanctions, or the like, and that Health Plan is solely responsible for monitoring and oversight of any subcontracted work. [Exhibit B, Part 4, Section 11(a)]

8. Provider understands and agrees that Health Plan must provide OHA with a list of subcontractors (including any work that Provider further subcontracts) and activities required to be performed under such subcontracts, including this Agreement, and shall include: (i) the legal name of Provider and each direct or indirect subcontractor, (ii) the scope of work and/or activities being subcontracted to each direct or indirect subcontractor, (iii) the current risk level of Provider as determined by Health Plan based on the level of Member impact of Provider's Work, the results of any previous Provider Performance Report(s), and any other factors deemed applicable by Health Plan or OHA or any combination thereof (provided, however, that Health Plan must apply the following OHA criteria to identify a High risk Provider, where Provider shall be considered High risk if the Provider: (a) provides direct service to Members or whose Work directly impacts Member care or treatment, or (b) has one or more formal review findings within the last three (3) years for which OHA or Health Plan or both has required the Provider to undertake any corrective action, or (c) both (a) and (b) above, (iv) copies of the ownership disclosure form, if applicable for Provider, (v) information about any ownership stake between Health Plan and Provider, if any, and (vi) an attestation from Health Plan regarding Paragraphs 3 through 5 above and that this Exhibit exists. [Exhibit B, Part 4, Section 11(a)]

9. Provider understands and agrees that the following obligations may not be Delegated to a third party: (i) oversight and monitoring of Quality Improvement activities, and (ii) adjudication of member grievances and appeals. [Exhibit B, Part 4, Section 11(a)]

10. Provider understands and agrees that Provider must respond and remedy any deficiencies identified in Provider's performance of the work or services to be performed under this Agreement, in the timeframe reasonably determined by Health Plan. [Exhibit B, Part 4, Section 11(a)]

11. Provider acknowledges and agrees that it may not bill Members for services that are not Covered Services under the OHA Contracts unless there is a full written disclosure or waiver on file, signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-3565. [Exhibit B, Part 4, Section 11(a)]

12. Provider acknowledges receiving a copy of Health Plan's written procedures for its Grievance and Appeal System, Agrees to comply with the requirements therein, and agrees to provide those written procedures to any subcontractors of Provider's services provided hereunder. [Exhibit B, Part 4, Section 11(a); Exhibit I, Section 1(b)(1)]

13. Provider understands and agrees that Health Plan shall monitor and audit Provider's performance on an ongoing basis and also perform timely, formal reviews of compliance with all obligations under this Agreement for the purpose of evaluating Provider's performance, which must identify any deficiencies and areas for improvement. Provider also understands and agrees to cooperate with Health Plan in the performance of such ongoing monitoring and review. Further, Provider understands and agrees that the annual report must minimally include the following: (i) an assessment of the quality of Provider's performance of the work performed pursuant to this Agreement, (ii) any complaints or grievances filed in

relation to such work, (iii) any late submission of reporting deliverables or incomplete data, (iv) whether Provider's employees are screened and monitored for federal exclusion from participation in Medicaid, (v) the adequacy of Provider's compliance functions, and (vi) any deficiencies that have been identified by OHA related to Provider's work performed pursuant to this Agreement. Provider understands and agrees that Health Plan may satisfy these requirements by submitting to OHA the results of a compliance review conducted by Health Plan, or a parent company or subsidiary, in relation to a Medicare Advantage subcontract with Provider if the work in question under both contracts is identical and the time period for the review is identical or inclusive of the time period for a report under this Agreement. Finally, Provider understands and agrees that Health Plan shall provide OHA with a copy of each review or an attestation, as provided for in the CCO Contracts. [Exhibit B, Part 4, Section 11(a)-(b)]

14. Provider agrees that it shall be placed under a corrective action plan ("CAP") if Health Plan identifies any deficiencies or areas for improvement in the ongoing monitoring or annual report and that Health Plan is required to provide a copy of such CAP to OHA, as well as any updates to the CAP, notification that the CAP was successfully addressed, and notification if Provider fails to complete a CAP by the designated deadline. [Exhibit B, Part 4, Section 11(a)]

15. Provider understands and agrees that Health Plan has the right to take remedial action, pass down or impose Sanctions, and that Health Plan intends this Agreement to reflect that Health Plan has the substantively the same rights as OHA has in the OHA Contracts, if Provider's performance is inadequate to meet the requirements of the OHA Contracts. [Exhibit B, Part 4, Section 11(b)]

16. Provider acknowledges and agrees that, notwithstanding any provision of this Agreement to the contrary, that Health Plan has the right to revoke delegation of any activities or obligations from the OHA Contracts that are included in this Agreement and to specify other remedies in instances where OHA or Health Plan determine Provider has breached the terms of this Agreement; provided, however, that Health Plan shall work with Provider to allow Provider reasonable time to cure any such breach. [Exhibit B, Part 4, Section 11(b)]

17. Provider acknowledges and agrees to comply with the payment, withholding, incentive, and other requirements set forth in 42 CFR §438.6 that is applicable to the work or services performed pursuant to this Agreement. [Exhibit B, Part 4, Section 11(b)]

18. Provider agrees to submit to Health Plan Valid Claims for services, including all the fields and information needed to allow the claim to be processed, within the timeframes for valid, accurate, Encounter Data submission as required by the OHA Contracts. [Exhibit B, Part 4, Section 11(b)]

19. Provider expressly agrees to comply with all Applicable Laws, including without limitation, all Medicaid laws, rules, regulations, all federal laws, rules, regulations governing Basic Health Programs, and all Oregon state laws, rules, and regulations governing OHP Bridge-Basic Health Program, as well as sub-regulatory guidance and contract provisions. [Exhibit B, Part 4, Section 11(b)]

20. Provider expressly agrees that Health Plan, OHA, the Oregon Secretary of State, the Center for Medicare & Medicaid Services, the U.S. Health & Human Services, the Office of the Inspector General, the Comptroller General of the United States, or their duly authorized representatives and designees, or all of them or any combination of them, have the right to audit, evaluate, and inspect any books, Records, contracts, computers, or other electronic systems of Provider, or of Provider's subcontractor, that pertain to any aspect of the services and activities performed, or determination of amounts payable under the OHA Contracts. Provider agrees that such right shall exist for a period of ten (10) years from the date this Agreement terminates or from the date of completion of any audit, whichever is later. Further, Provider

agrees that if Health Plan, OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, then OHA, CMS or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. [Exhibit B, Part 4, Section 11(b)]

21. Provider agrees to make available, for purposes of audit, evaluation, or inspection of its premises, physical facilities, equipment, books, Records, contracts, computer, or other electronic systems relating to its Members. [Exhibit B, Part 4, Section 11(b); Exhibit D, Section 15]

22. Provider agrees to respond and comply in a timely manner to any and all requests from OHA or its designee for information or documentation pertaining to Work outlined in the OHA Contracts. [Exhibit B, Part 4, Section 12(b)]

23. Pursuant to 42 CFR §438.608, to the extent this Agreement requires Provider to provide services to Members or processing and paying for claims, Provider agrees to adopt and comply with Health Plan's Fraud, Waste, and Abuse policies, procedures, reporting obligations, and annual Fraud, Waste, and Abuse Prevention Plan, as well as the obligations, terms and conditions provided in Exhibit B, Part 9 of the OHA Contracts. Further, Provider agrees, unless expressly provided otherwise in the applicable provision, to report immediately to Health Plan any provider and Member Fraud, Waste, or Abuse ("FWA"), which Health Plan will report to OHA or the applicable agency, division, or entity. [Exhibit B, Part 4, Section 11(b)]

23.1 In addition to the preceding paragraph, if Provider provides services to Members or processes and pays for claims, then Provider agrees to comply with Exhibit B, Part 9, Sections 11-18 of the OHA Contracts, related to FWA and compliance activities. [Exhibit B, Part 9, Section 10]

24. Provider agrees to meet the standards for timely access to care and services, as set forth in the OHA Contracts and OAR 410-141-3515, which includes providing services within a timeframe that takes into account the urgency of the need for services. [Exhibit B, Part 4, Section 11(b)]

25. Provider agrees to report promptly to Health Plan any Other Primary, third-party Insurance to which a Member may be entitled. [Exhibit B, Part 4, Section 11(b)]

26. Provider agrees to request, obtain, and provide, in a timely manner as noted in any Health Plan TPL Guidebook or upon Health Plan or OHA request, with all Third-Party Liability eligibility information and any other information requested by Health Plan or OHA, as applicable, in order to assist in the pursuit of financial recovery. Provider also agrees to enter into any data sharing agreements required by OHA or its PIL Unit. [Exhibit B, Part 4, Section 11(b); Part 8, Section 17(f)(1); Part 8, Section 18(s)(5)]

27. Provider agrees to document, maintain, and provide to Health Plan all Encounter Data records that document Provider's reimbursement to federally qualified health centers, Rural Health Centers and Indian Health Care Providers and to provide such documents and records to Health Plan upon request. [Exhibit B, Part 4, Section 11(c)]

28. Provider understands and agrees that if Health Plan is not paid or not eligible for payment by OHA for services provided, neither will Provider be paid or be eligible for payment. [Exhibit B, Part 4, Section 11(d)]

29. Provider understands and agrees that Health Plan will provide a copy of this Agreement to OHA upon OHA's request. [Exhibit B, Part 4, Section 11(e)]

30. In accordance with the OHA Contracts, Provider understands and agrees to comply with the following provisions:

30.1 Adhere to the policies and procedures set forth in Health Plan's Service Authorization Handbook. [Exhibit B, Part 2, Section 3(a)]

30.2 Obtain Prior Authorization for Covered Services, as noted on Health Plan's website. [Exhibit B, Part 2, Section 3(b)(3)]

30.3 For preventive Covered Services, report all such services provided to Members to Health Plan and such services are subject to Health Plan's Medical Case Management and Record Keeping responsibilities. [Exhibit B, Part 2, Section 6(a)(3)]

30.4 Ensure that each Member is free to exercise their Member rights, and that the exercise of those rights does not adversely affect the way Health Plan, its staff, Provider, Participating Providers, or OHA, treat the Member. [Exhibit B, Part 3, Section 2(o)]

30.5 Adhere to Health Plan's policies for Provider directories, including updating the information therein. [Exhibit B, Part 3, Section 6(i)]

30.6 Meet the special needs of Members who require accommodations because of a disability or limited English proficiency. [Exhibit B, Part 4, Section 2(k)]

30.7 Ensure that all Traditional Health Workers undergo and meet the requirements for, and pass the required background check, as described in OAR 950-060-0070 [Exhibit B, part 4, Section 4(a)(6)]

30.8 Consistent with 42 CFR §438.106 and §438.230, not bill any Member for Covered Services in any amount greater than would be owed if Health Plan provided the services directly, and comply with OAR 410-120-1280 relating to when a Provider may bill a Medicaid recipient and when a Provider may send a Medicaid recipient to collections for unpaid medical bills. [Exhibit B, Part 8, Section 4(f)]

30.9 If any of Health Plan's OHA Contracts are terminated, make available to OHA or another health plan to which OHA has assigned the Member, copies of medical, Behavioral Health, Oral Health, and managed Long Term Services and Supports records, patient files, and any other information necessary for the efficient care management of Members as determined by OHA, in such format(s) as directed by OHA and provided without expense to OHA or the Member. [Exhibit D, Section 10(c)(6)]

30.10 Section 1 (Governing Law, Consent to Jurisdiction, 2 (Compliance with Applicable Law), 3 (Independent Contractor), 4 (Representations and Warranties), 15 (Access to Records and Facilities; Records Retention; Information Sharing), 16 (Force Majeure), 18 (Assignment of Contract, Successors in Interest), 19 (Subcontracts), 24 (Survival), 30 (Equal Access), 31 (Media Disclosure), and 32 (Mandatory Reporting of Abuse) of Exhibit D of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [Exhibit D, Section 19]

30.11 Exhibit E of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [Exhibit E]

30.11 Exhibit F of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [Exhibit F]

30.13 If any part of the Grievance process is performed by Provider pursuant to this Agreement, meet the requirements of the OHA Contracts, (i) comply with OAR 410-141-3835 through 410-141-3915 and 42 CFR §438.400 through §438.424, (ii) cooperate with any investigation or resolution of a Grievance by either or both DHS's Client Services Unit and OHA's Ombudsperson

as expeditiously as the Member's health condition requires, and (iii) provide the data necessary for Health Plan to fulfill its reporting obligations to OHA. [Exhibit I, Section 1(e)(10), Section 2(d), Section 10]

30.14 If Provider is required to collect and submit any demographic data to Health Plan, then Provider shall include REALD data in that data collection and submission. [Exhibit K, Section 12(b)]

30.15 Respond promptly and truthfully to all inquiries made by OHA or by the Oregon Department of Consumer and Business Services ("DCBS") concerning any subcontracted work and transactions pursuant to or connected to the OHA Contracts, using the form of communication requested by OHA or DCBS. [Exhibit L, Section 3(a)]

30.16 If Provider makes any prior authorization determinations for substance use disorder treatment services and supports, then Provider shall ensure its staff have a working knowledge of the ASAM Criteria, as required by the OHP SUD 1115 demonstration waiver. Further, Provider shall confirm compliance with this requirement upon request of Health Plan, so that Health Plan can submit an attestation of compliance to OHA. [Exhibit M, Section 7(j)]

30.17 Provide all required information to Health Plan necessary for Health Plan to submit an annual Behavioral Health report to OHA. [Exhibit M, Section 14, 23]

30.18 Take any Health Plan required training or otherwise provide training within Provider's operations regarding recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://tramainformedoregon.org/tic-intro-training-modules/), and, if applicable, enroll in, and provide timely updates to, OHA's Centralized Behavioral Health Provider Directory. [Exhibit M, Section 24]

30.19 Exhibit N of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [Exhibit N]

31. Provider agrees to comply with Section C Part 10 of Attachment I of the 2017-2022 Medicaid 1115 Waiver regarding timely Payment to Indian Health Care Providers. [OAR 410-141-3505]

32. Provider acknowledges that it has received a copy of the current version of the OHA Contracts, with the exception of Exhibit C.

33. Miscellaneous.

33.1 *Provider Certification.* Provider hereby certifies that all claims submissions and/or information received from Provider are true, accurate, and complete, and that payment of the claims by Health Plan, or its subcontractor, for Health Plan Members will be from federal and state funds, and therefore any falsification, or concealment of material fact by Provider when submitting claims may be prosecuted under federal and state laws. Provider shall submit such claims in a timely fashion such that Health Plan may comply with any applicable Encounter Data submission timeframes, and shall include sufficient data and information for OHA to secure federal drug rebates for outpatient drugs provided to Health Plan's Members under this Agreement, if any. Provider hereby further certifies that it is not and will not be compensated for any work performed under this Agreement by any other source or entity.

33.2 *Indemnification.* Notwithstanding any indemnification provision in this Agreement, as it pertains to Health Plan Members, Provider shall defend, save, hold harmless and indemnify Health Plan, the State of Oregon, and their respective officers, employees, subcontractors, agents, insurers, and attorneys from and against all of the following (here "Indemnifiable Events"): all claims, suits, actions, losses, damages, liabilities, settlements, costs and expenses of any nature

whatsoever (including reasonable attorneys' fees and expenses at trial, at mediation, on appeal and in connection with any petition for review) resulting from, arising out of, or relating to the activities of Provider or its officers, employees, subcontractors, agents, insurers, and attorneys (or any combination of them) under this Agreement. Indemnifiable Events include, without limitation (i) unauthorized disclosure of confidential records or Protected Information, including without limitation records and information protected by HIPAA or 42 CFR Part 2, (ii) any breach of this Exhibit or the Agreement, (iii) impermissible denial of Covered Services, (iv) failure to comply with any reporting obligations under this Agreement, and (v) failure to enforce any obligation of a subcontractor under this Agreement.

Provider shall have control of the defense and settlement of any claim this is subject to this Section 33.2; however, neither Provider nor any attorney engaged by Provider, shall defend the claim in the name of the State of Oregon or any agency of the State of Oregon, nor purport to act as legal representative of the State of Oregon or any of its agencies, without first receiving the prior written approval of the Oregon Attorney General to act as legal counsel for the State of Oregon; nor shall Provider settle any claim on behalf of the State of Oregon without the prior written approval of the Attorney General. The State of Oregon may, at its election, assume its own defense and settlement in the event that the State of Oregon determines that Provider is prohibited from defending the State of Oregon, or is not adequately defending its interests. The State of Oregon may, at its own election and expense, assume its own defense and settlement in the event the State of Oregon determines that an important governmental principle is at issue.

Provider shall ensure that the State of Oregon, Department of Human Services is not held liable for (i) any of Provider's debts or liabilities in the event of insolvency, regardless of whether such liabilities arise out of such parties' insolvency or bankruptcy; (ii) Covered Services authorized or required to be provided by Provider under this Agreement, regardless of whether such Covered Services were provided or performed by Provider, Provider's subcontractor, or Provider's Participating or Non-Participating Provider; or (iii) both (i) and (ii) of this sentence.

Notwithstanding the foregoing, no party shall be liable to any other party for lost profits, damages related to diminution in value, incidental, special, punitive, or consequential damages under this Agreement; provided, however, Provider shall be liable (i) for civil penalties assessed against Health Plan by OHA related to a breach of this Agreement by Provider; (ii) for Liquidated Damages assessed against Health Plan by OHA related to a breach of this Agreement by Provider; (iii) under the Oregon False Claims Act; (iv) for Indemnifiable Events as noted above, (v) claims arising out of or related to unauthorized disclosure of confidential records or information of Members (or both of them), including without limitation records or information protected by HIPAA or 42 CFR Part 2; (vi) any OHA expenses assessed to Health Plan for termination of the OHA Contracts that are related to a breach of this Agreement by Provider; or (vii) damages specifically authorized under another provision of this Agreement. [Exhibit D, Section 8 and 12]

33.3 *Force Majeure.* Neither OHA, Provider nor Health Plan shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, natural causes, government fiat, terrorist acts, other acts of political sabotage or war, earthquake, tsunami, flood, or other similar natural disaster, which is beyond the reasonable control of the affected party. Each party shall, however, make all reasonable efforts to remove or eliminate such cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement. OHA or Health Plan may terminate this Agreement upon written notice to Provider after reasonably determining that the delay or default will likely prevent successful performance of this Agreement.

If the rendering of services or benefits under this Agreement is delayed or made impractical due to any of the circumstances listed in the preceding paragraph, care may be

deferred until after resolution of those circumstances, except in the following situations: (a) care is needed for Emergency Services; (b) care is needed for Urgent Care Services; or (c) care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than thirty (30) days.

If any of the circumstances listed in the first paragraph of this section disrupts normal execution of Provider's duties under this Agreement, Provider shall notify Members in writing of the situation and direct Members to bring serious health care needs to Provider's attention. [Exhibit D, Section 16]

33.4 *No Third Party Beneficiaries.* Health Plan and Provider are the only parties to this Agreement and the only parties entitled to enforce its terms; provided, however, that OHA and other government bodies have the rights specifically identified in this Agreement. The parties agree that Provider's performance under this Agreement is solely for the benefit of Health Plan to fulfill its OHA Contracts obligations and assist OHA in accomplishing its statutory mission. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement. This provision shall survive the termination of this Agreement for any reason.

33.5 *Severability.* If any term or provision of this Agreement is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Agreement did not contain the particular term or provision held to be invalid.

33.6 *Termination; Revocation of Delegated Activities.* Notwithstanding any other provision in this Agreement, Health Plan may terminate this Agreement or impose Sanctions, as provided in the OHA Contracts, if Provider's performance is inadequate to meet the requirements of the OHA Contracts.

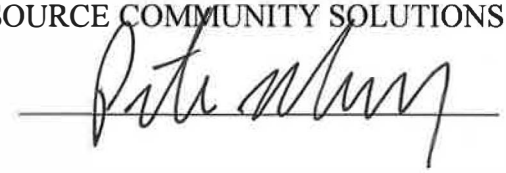
33.7 *Subcontractor/FDR Manual.* Provider shall comply with the due dates and requirements in Health Plan's Subcontractor/FDR Manual (the "Manual"), as amended, once that Manual is finalized and posted. Provider is responsible for reviewing the Manual periodically in order to know the current requirements.

34. Differences between the CCO Contract, the Non-Medicaid Contract, and/or the OHP Bridge-BHP Contract. There are a few language differences between the CCO Contract, the Non-Medicaid Contract, and OHP Bridge-BHP. To the extent that Provider only works with one population or the other, that contract will apply; however, to the extent that Provider works with one or more populations, all relevant contracts will apply, as applicable, to the situation depending on what work and what population is involved.

35. If Provider is also a HRSN Service Provider, then Provider understands and agrees that it is prohibited from having any involvement in (i) authorizing or denying any HRSN Service or (ii) service planning for an HRSN Eligible Member. [HRSN Amendment #24, Section 16(i)(3)]

36. Provider agrees and acknowledges that the OHA periodically amends the OHA Contracts. Provider also agrees and acknowledges that Health Plan may periodically send an updated version of this Exhibit that will automatically replace this Exhibit and be incorporated into Provider's contract with Health Plan.

IN WITNESS WHEREOF, the Parties have executed this Agreement by and through their duly authorized representatives.

PACIFICSOURCE COMMUNITY SOLUTIONS		DESCHUTES COUNTY HEALTH SERVICES	
By:		By:	(Signature)
	Peter McGarry		Anthony DeBone
			(Print or type name)
Title:	Vice President – Provider Network	Title:	Chair, Board of County Commissioners
Date:	1-6-25	Date:	
Address:	PO Box 7469 Bend, OR 97708	Address:	2577 NE Courtney Drive Bend, OR 97701